Introduction

1. The Scottish Executive Health Department welcomed the Auditor General’s Report “Overview of the Financial Performance of the NHS in Scotland 2003-04” which was published on 20 December 2004. The Department further welcomes the Audit Committee’s 5th Report 2005 published on 1 June 2005 and notes that the report identifies a number of issues arising at both Health Department and NHS Board level.

2. The Health Department welcomes the Committee’s acknowledgement that the NHS works well in many areas and its recognition of the complexity of the task facing the Department and NHS Boards. The Department in turn acknowledges the Committee’s concerns about the scale and pace of improvement in some areas.

3. The Department has already taken action to tackle issues raised by the Committee. These include:

   • Health improvement initiatives including legislating to prevent smoking in enclosed public places.

   • Faster treatment through more use of day surgery, and additional capacity including the independent sector.

   • The introduction of a tariff system, initially on cross boundary flows, which will create an incentive for efficiency in costs, and for better recording of data.

   • People being rewarded fairly for the jobs they do.

   • The Executive has recently published Building a Health Service Fit for the future and will present its response to this review shortly.

   • An enhanced approach within the Department to NHS delivery, supported by a new planning framework, performance support and improvement arrangements, announced on 29 July.

   • On finances: Most Boards improve services year on year while maintaining financial balance. The Scottish Executive has announced how it proposes to resolve the accumulated deficit in Argyll and Clyde. All other Boards in 2003-04 were either in surplus or planned to reach that position within time frames agreed with SEHD.

   • Healthcare is changing for the benefit of patients. Replacing inpatient or day case surgery by an outpatient procedure is not a reduction in productivity. The traditional activity figures quoted for hospital-provided services fail to record the new work being done more locally by other health professionals for example in nurse-led clinic and by AHPs. We are already collecting new data to reflect these changes in care delivery. Managing patients locally in primary care taking advantage of new
therapies rather than in hospital is not a reduction in productivity. On the measures that matter to patients, including waiting, NHSScotland performance is improving.

- On the new contracts: We note the Committee’s conclusions about pay modernisation. The Committee’s report is on the financial performance of NHSScotland in 2003-04, when none of the strands of pay modernisation had yet been introduced. Since then we have seen the first year of implementation of the new GMS and consultant contracts and the introduction of Agenda for Change. Given that pay modernisation is about fair pay and redesign in the long-term, it is premature to judge it.

- Our priorities are to improve health and to deliver better services to patients. To do that we have to recruit and retain staff within NHS Scotland. Over the last year, we have reached agreements for a range of staff from porters to consultants which are designed to recruit and retain more staff, offer better career paths and enable enhanced quality and greater productivity.

4. This paper is the Department’s formal response to the Committee’s report. It addresses the 42 principal conclusions and recommendations. These are set out in the attached annex.

Scottish Executive Health Department
July 2005
Dear Colleague

DELIVERING THE BENEFITS OF PAY MODERNISATION IN NHSSCOTLAND

Summary

1. This HDL:
   - confirms the approach to be taken by NHS Boards in fully implementing the new Consultant Contract, the new General Medical Services (GMS) contract and Agenda for Change, together known as pay modernisation;
   - outlines the performance management arrangements for ensuring delivery of benefits from pay modernisation;
   - provides links to supporting guidance on pay modernisation benefits.

Background

2. All three existing strands of pay modernisation (to be joined soon by new contracts for pharmacy and dentistry) form a unified “toolkit” with a common goal – to reward, motivate and free up staff to deliver redesigned, improved services to patients.

3. Implementation of pay modernisation requires the full delivery of each of the individual contracts if the potential benefits in service improvements are to be realised. Delivery must be linked to achievement of the Department’s overall policy objectives for NHSScotland, and in particular focus on:
   - improved productivity
   - improved services for the public, including delivery of the clinical priorities of Cancer, CHD/Stroke and Mental Health
   - service redesign around the needs of patients

1 July 2005

Addresses

For action
Chairs, NHS Boards and Special Health Boards
Chief Executives, NHS Boards and Special Health Boards

For information
Medical Directors, NHS Boards and Special Health Boards
Directors of Nursing, NHS Boards and Special Health Boards
Directors of Human Resources, NHS Boards and Special Health Boards
Members, Scottish Partnership Forum
Members, HR Forum
Members, SPRIG

Enquiries to:
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EDINBURGH EH1 3DG

Tel: 0131-244 2473
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• improved recruitment and retention
• improved team working, and
• improved management and development of staff.

4. More specifically, implementation of pay modernisation must support the delivery of key NHS priorities, particularly:

- National access/waiting targets
- Improved delivery of unscheduled care
- Chronic disease management
- Integrated care
- Integrated service and workforce planning
- Staff governance
- Service redesign in line with local priorities

5. Workforce productivity is a key aspect of delivery against these objectives. You will be aware that the Department has commissioned work on productivity and will shortly be able to direct Boards to high-level data to enable them to analyse and benchmark their workforce productivity against the rest of NHSScotland.

6. A major investment of public money has been made in support of these contracts, and this must be accounted for through better services for patients. Agreements have been reached collectively with staff and professional organisations, and endorsed at staff ballots, that this investment will be used to secure increased flexibility in the workforce and to enable new ways of working to transform the delivery of care to patients. Delivery of these benefits will be achieved by management, staff representatives and staff themselves working in partnership to achieve NHS priorities through support for redesign and improvements in services, on the basis of value for money – making a difference in a way that can be demonstrated to the public.

7. The priorities listed at paragraph 4 are wide-ranging and challenging. Pay modernisation should not be an ‘extra burden’ which distracts from the focus of delivering on these existing priorities, but should rather be used as a tool across the whole range of priorities which helps and supports systems to manage and deliver them, from waiting times targets to chronic disease management, integrated care and workforce planning.

8. Pay modernisation represents a radical and major overhaul of previous arrangements. The Scottish Executive Health Department acknowledges and commends the enormous efforts already made by NHS Boards and staff, and by independent contractors and their staff, in introducing the new consultant and GMS contracts. These contracts have now entered their second year of implementation and are already making a difference. NHS Scotland is now delivering benefits associated with, for example, job planning in the consultant contract (more transparent scheduling of activity and provision of safe working hours) and the Quality and Outcomes Framework in primary medical services (reward linked directly to patient outcomes in primary care).

9. Implementation of Agenda for Change is not as far advanced as the other contracts. Much effort in 2005 will need to focus on the core requirement of assimilating staff onto the new Agenda for Change terms and conditions, and the completion of this initial phase of work will in itself be a major achievement. Assimilation must be a core objective of any pay modernisation delivery plan, given the fact that Agenda for Change affects over 90% of NHSScotland staff and is still in the early stages of implementation.
10. Equally delivery of pay modernisation is a journey that means much more than the initial transfer of staff onto the new contracts. It is an ongoing means to an end - a key tool to help secure sustainable, safe and effective changes to service provision that deliver better care for patients. And it will do much of this by effecting deep and incremental cultural change in behaviours, attitudes and ways of working. We are therefore at the very start of the journey. Initial introduction of the new contracts must now be built on by using pay modernisation to help deliver service change that will provide lasting improvements to patient care.

11. This means forging clear links at all levels (national, regional and Board) between pay modernisation and achieving objectives for service improvement. At national level this links with the work of the Centre for Change and Innovation. At Board and regional level it means close joint working between Board and regional redesign committees, pay modernisation boards and regional workforce networks identifying the ways in which pay modernisation can lever in or inspire the change being driven by service redesign committees.

**Action**

12. To achieve the full range of benefits Boards need to manage strategically the pay modernisation ‘toolkit’ to help deliver service change. This HDL does not seek to ‘micro-manage’ the ways in which Boards go about delivering pay modernisation benefits, but rather to establish a supportive framework which provides a clear focus on the identification and measurement of outcomes through improvements in patient care that support the objectives in each Board’s local health plan – objectives that will be subject to increasingly vigorous performance management.

13. The emphasis of the actions outlined at paragraphs 14 to 16 is therefore not so much on the new pay systems per se, but rather on the delivery of service improvements and outcomes (expressed in the NHS priorities listed at paragraph 4 and in local Board plans) achieved partly or wholly through pay modernisation.

14. Boards are therefore asked to:

- ensure that realising the benefits of pay modernisation is critical. Board Chairs and Chief Executives should make sure that their executive teams are focused on this as a key factor supporting the achievement of challenging performance and service targets;
- ensure that Board Chairs receive regular reports from Chief Executives on implementation progress;
- ensure that Chief Executives identify a Director (who would normally be expected to be the Director of Human Resources) to lead this work, and the key responsibilities of other Directors and the structures required to support this work as a ‘joined-up’ corporate effort, making effective links with the Board’s performance management and service planning functions, the service redesign committee, the area clinical forum and the regional service and workforce planning arrangements;
- ensure that area partnership forums are linked into this work;
- ensure that the benefits are effectively communicated, through concrete examples, to their local communities. This will be a cornerstone of the national demonstration of benefits in a way which the public and staff can understand;
- ensure that Board development plans reflect the organisational development aspects of pay modernisation including clinical leadership development;
• prepare an initial pay modernisation benefits delivery plan which details how the Board is using and will use pay modernisation for the rest of this financial year (to 31 March 2006) to help achieve benefits for patients through the delivery of key national objectives.
• Ensure that the delivery plan shows attainment of pay modernisation benefits against specific measurable and timebound indicators and demonstrate progress on the use of pay modernisation to deliver service change. It will normally be signed off by the Board Director of Human Resources, having been approved by the Chair and Chief Executive and agreed by the Board’s Pay Modernisation Board and Staff Governance Committee.

15. Once received, Ministers will use the plans to performance manage and guide progress on benefits realisation. Boards are asked to submit a six-monthly progress report at 31 March 2006, detailing progress against their initial plans and an action plan for the following six months or beyond. The plans and progress reports will be shared with the HR Forum and the Scottish Partnership Forum. These plans and progress reports should describe how Boards are:

- using pay modernisation to help deliver key NHS priorities, as described at paragraph 4;
- using pay modernisation in an integrated way, as described at paragraph 19;
- fully delivering each of the individual contracts, as described at paragraph 3;
- sharing innovation and best practice/learning across regions and nationally.

16. Boards’ plans and progress reports should not take a mechanistic ‘tick box’ approach or focus on the new pay systems as an end in themselves, but should explain fully how strategic outcomes in terms of improvements in patient care are being aided - whether wholly or in part - by the use of pay modernisation as a lever for change. Reporting progress in this way will not only allow Boards to fulfill their responsibilities to Ministers in accounting for the delivery of pay modernisation but will also give the Department a national overview that will enable it to showcase best practice, or identify any problems and take timely action to provide support where necessary.

17. The standard template to be used for the initial benefits delivery plan and the progress report is attached at Annex A. Boards are requested to finalise and submit their first returns by 30 September 2005 (draft plans to be submitted by 31 August 2005). Both draft and final plans should be submitted to Brenda Burnett, Directorate of Human Resources, Scottish Executive Health Department, GF Rear, St Andrew’s House, Edinburgh EH1 3DG (e-mail: Brenda.burnett@scotland.gsi.gov.uk). To avoid unnecessary duplication this HDL supersedes any previous requests for information on the delivery of pay modernisation benefits. Further guidance will be issued in due course on what the reporting arrangements will be for the period beyond March 2006. Arrangements will be put in place to provide regular progress reports on the delivery of benefits.

18. Boards can expect vigorous follow-up action by SEHD to ensure they are meeting their national performance targets, and to take remedial action if the targets are at risk. Satisfactory progress by Boards towards pay modernisation targets will be an important identification that national performance targets will be delivered. Boards’ performance against national targets, supported by enabling measures including performance on pay modernisation, will be an important issue for Boards’ annual reviews with the Health Minister.
An Integrated Approach

19. As noted above, implementation of pay modernisation must be integrated
   • across the three contracts; and
   • with other service developments (eg local service redesign, clinical strategies around cancer, CHD/Stroke, mental health and children’s health, regional service planning, development of Community Health Partnerships etc) to maximise potential benefits.

20. An example of the potential benefits to be gained from an integrated approach can be found in the response to the pressures on medical workforce capacity flowing from Modernising Medical Careers, and the opportunities for clinical workforce redesign to respond to this development. Many developments are now led by other clinical professionals and this opportunity should be enhanced in the interests of patient needs. We will be interested to see how Boards use the new contracts to address this challenge.

Further information

21. Further information on the benefits to be gained from the contracts are to be found in the following supporting guidance:-
   • For the nGMS contract, the “Primary Medical Services Strategic Tests” letter and assessment Process http://www.show.scot.nhs.uk/sehd/paymodernisation/gms/index.htm
   • For the new consultant contract, the ‘PMT 16’ letter: http://www.show.scot.nhs.uk/sehd/paymodernisation/ConsultantContract.htm
   • For Agenda for Change, the November 2004 National Agreement Annex E “Partnership Agreement Success Criteria”: http://www.show.scot.nhs.uk/sehd/paymodernisation/AfC/docs/afc_agreement_final.pdf

22. The national Pay Modernisation Team supports NHS Boards in delivering pay modernisation and its website contains examples, based on existing experience in NHSScotland, of ways in which the contracts can be used to deliver benefits. The Team can direct NHS Boards to additional materials and information from across Scotland and the UK and also shares learning and innovation. The Team’s website is at www.show.scot.nhs.uk/sehd/paymodernisation.

Conclusion

23. This HDL has emphasised the importance of delivering the benefits of pay modernisation; the approach to be taken in planning for and delivering benefits; and the mechanisms by which performance will be monitored and managed. It sees pay modernisation as a key tool to help Boards to achieve safe, sustainable and effective service change that delivers service improvements, enabling Boards to meet NHSScotland’s key priorities. It therefore highlights the achievement of national targets, including better access to service and better outcomes for patients, as the key objective in achieving pay modernisation benefits.
24. Good progress has already been made in introducing the contracts and with continued focus the full implementation of pay modernisation will deliver real and lasting benefits for patients, staff and the NHS in Scotland.

Yours sincerely

KEVIN WOODS
Chief Executive of NHSScotland and Head of the Health Department
ANNEX A

DELIVERING THE BENEFITS OF PAY MODERNISATION: HEALTH BOARD
ANNUAL BENEFITS DELIVERY PLAN
AND SIX MONTHLY PROGRESS REPORTS

Context

1. The HDL dated 1 July 2005, Delivering the benefits of pay modernisation in NHSScotland, requests all Health Boards to:
   - provide by 30 September 2005 an initial Pay Modernisation Benefits Delivery Plan that describes how it is delivering the benefits of pay modernisation;
   - produce a progress report at 31 March 2006 showing attainment of pay modernisation benefits against measurable performance indicators, demonstrating progress made on the use of pay modernisation to deliver service change that improves care to patients, and setting out an action plan for the following six months or beyond.

Format for annual delivery plan and progress reports

2. Health Boards should develop a succinct but composite action plan that addresses the priorities listed at paragraph 4 and specifies how pay modernisation is being used to deliver benefits through service improvements. The plan should be specific about which aspects of each contract are being used in what timeframe to ensure improvements in meeting service priorities.

3. The attached pro-forma and summary cover sheet should be used for the annual Pay Modernisation Benefits Delivery Plan and progress reports.

4. Paragraph 4 of the HDL lists the key NHS priorities to be supported by pay modernisation:
   - Meeting national access/waiting targets and objectives for the clinical priorities (Cancer, CHD/Stroke, Mental Health)
   - Improved delivery of unscheduled care
   - The implementation of chronic disease management programmes
   - The development and implementation of integrated care
   - The delivery of integrated service and workforce planning
   - The implementation of Staff Governance arrangements
   - Service redesign in line with local priorities

5. Health Boards should list the specific local targets to be achieved under each of these priorities (as expressed in each Board’s local priorities) and record them on the summary cover sheet to the pro-forma. Boards should then identify the pay modernisation actions they are taking to help deliver these targets, identifying how they are using pay modernisation as a lever to achieve their aims. The Delivery Plan should show the actions to be achieved over the period to 31 March 2006 and, where possible, beyond.

6. The Delivery Plan, based on the information above, will therefore identify the pay modernisation levers which each Board is using to help meet measurable service delivery targets, and by what date. Each Plan should make clear which benefits will be delivered between completion of the Plan and the time of the follow-up progress report.
7. Each Plan should provide examples against the priorities listed above to demonstrate how pay modernisation is being used to improve service delivery. These should:

- include a clear narrative
- be supported by robust data, eg acquired from ISD sources (and including the baseline data referred to at paragraph 9)
- demonstrate how the achievement of NHS priorities are being aided by use of pay modernisation

8. The attached sample pro-forma provides a worked example of how Health Boards should complete the pro-forma.

**Related data gathering exercises**

9. Boards have supplied or are supplying the Pay Modernisation Team and SPRIG with baseline information on each contract as follows:

   a) data on the nGMS strategic tests;
   b) data for inclusion in the monthly *Agenda for Change* monitoring reports on matching and assimilation;
   c) data collected as part of the internal audit following the introduction of the new consultant contract, as requested in PMT 16;
   d) consultant contract activity data already collected by specialty and Health Board, accessible from the ISD website.

10. This information (on which further details can be accessed from the Pay Modernisation Team website at [www.show.scot.nhs.uk/sehd/paymodernisation](http://www.show.scot.nhs.uk/sehd/paymodernisation)) will form a baseline equating to correct implementation of the agreed terms and conditions, against which the delivery of benefits can then be measured.

**Next Steps**

11. Health Boards are requested to take the following action:

   a) Develop their initial Pay Modernisation Benefits Delivery Plan for the period between now and 31 March 2006 and beyond, and submit it by 30 September 2005 to the Director of Human Resources, SEHD (contact: Brenda Burnett, Directorate of Human Resources, Scottish Executive Health Department, GF Rear, St Andrew’s House, Edinburgh EH1 3DG (e-mail: Brenda.burnett@scotland.gsi.gov.uk)) who will then share it with the HR Forum and Scottish Partnership Forum. Plans should be signed off by the Health Board Chair and Chief Executive, having been agreed with the Board’s Pay Modernisation Board and Staff Governance Committee.
In addition, a draft of the initial draft Delivery Plan should be submitted to the Director of Human Resources in SEHD by 31 August 2005.

b) Prepare a progress report for submission by 31 March 2006 assessing achievement against objectives set in the initial plan, as well as the action plan for the following six months or beyond. Guidance on the reporting arrangements for periods beyond 31 March 2006 will be issued later this year.

SEHD
1 July 2005
HEALTH BOARD
PAY MODERNISATION BENEFITS DELIVERY PLAN
AND
PROGRESS REPORT
SUMMARY COVER SHEET

Health Board:

Contact:

Date:

Summary Page

NHS [insert name of Board here] priorities are:

1. Meeting national targets

2. Improved delivery of unscheduled care

3. The implementation of chronic disease management programmes

4. The development and implementation of integrated care
5. The delivery of integrated service and workforce planning

6. The implementation of the staff governance arrangements

7. Service redesign in line with local priorities
<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Specific Area</th>
<th>Supporting data to measure baseline and demonstrate progress</th>
<th>Actions to be taken</th>
<th>Anticipated Results (Quantifiable and with dates)</th>
<th>Progress</th>
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<tbody>
<tr>
<td>Meeting National Access/Waiting Times</td>
<td>Orthopaedics</td>
<td>Waiting times Information</td>
<td>Job plan reviews for all orthopaedic consultants with EPAs allocated to support waiting time reductions</td>
<td>Additional 2 clinics Per week</td>
<td>% of new patients increased to match Scotland average</td>
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<tr>
<td>ISD(M)53 Consultant Contract information</td>
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<td>Services objectives agreed with consultants to improve new follow up ratios and theatre utilisation rates</td>
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<td>Out patient information – new follow up ratios</td>
<td></td>
<td></td>
<td>New orthopaedic extended practice role developed for physiotherapist, supported by KSF and job evaluation</td>
<td>Additional clinic appointment capacity of 10 patients per week</td>
<td>Primary care referrals to secondary care reduced, waiting time for access to specialist reduced by 5 weeks</td>
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<td>Day case: in patient Ratios</td>
<td></td>
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<td>GP with special interest in orthopaedics appointed to support reduction in out-patient waiting time</td>
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<td>Theatre utilisation rates</td>
<td></td>
<td></td>
<td>Back pain service developed in primary care supported by extended role physiotherapist and GPwSI to reduce waiting time for patients and free up secondary care capacity</td>
<td>Waiting time for patients with back pain reduced by 5 weeks</td>
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<tr>
<td>NO.</td>
<td>PARA REF</td>
<td>PRINCIPAL CONCLUSIONS AND RECOMMENDATIONS</td>
<td>COMMENTS</td>
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<td><strong>FINANCIAL PERFORMANCE</strong></td>
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<td><strong>Background</strong></td>
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<td>1</td>
<td>15</td>
<td>The Committee welcomes the AGS report finding that systems of internal control are of a good standard in the NHS and that there were no qualifications to the &quot;true and fair&quot; auditors' opinions.</td>
<td>Noted. The Department also welcomes the AGS view that systems and standards of financial control within the NHS are of a good standard. The fact that there were no qualifications to the “true and fair” opinion is welcome evidence that they provide an accurate accounting record of the financial state of the NHS.</td>
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<td>2</td>
<td>16</td>
<td>However, on closer examination, this top-level picture of a system in balance does not tell the whole story. The report in fact paints a picture of building financial pressures.</td>
<td>Noted. We acknowledge that there were a number of financial pressures in the system in 2003/2004, but most NHS Boards managed these financial pressures within the overall resources available to them. The average annual increase since 1999 is 6.5%. It is for NHS Boards to manage the totality of their resources ensuring they are used efficiently and effectively to provide value for money and maximum benefit for patient care.</td>
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<td><strong>Uplift and Demands on the Service</strong></td>
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<td>20</td>
<td>Because so much of the additional investment is committed to meeting cost pressures, less money is available for funding new and improved local services. It is crucial therefore that national initiatives such as pay modernisation deliver significant benefits for patients.</td>
<td>Agreed. Pay modernisation needs to deliver significant benefits for patients. This is already happening and, as made clear in previous evidence, we have put arrangements in place through the work of the pay modernisation directors and their teams to support and help bring about beneficial service change through pay modernisation. We have also issued a Health Department Letter to all NHS Boards making clear how the Department will be performance managing the delivery of benefits from pay modernisation and the priority we attach to this. This is at Appendix A.</td>
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<td><strong>Drugs Costs</strong></td>
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<td>4</td>
<td>22</td>
<td>The Committee refers the Department to the recommendations in its 3rd report 2004.</td>
<td>Noted. The Department responded on 24 March 2004 to the Committee’s 3rd report 2004 on the June 2003 report from Audit Scotland – Supporting Prescribing in General Practice. It also provided further clarification on 23 June 2004 in response to additional questions from the Committee, who in their final letter of 21 September 2004 agreed to note the response and take no further action.</td>
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<td>The Department must do more to ensure efficient and effective prescribing. In particular IT programmes to improve prescribing must deliver better services for patients more quickly. This work must encompass both hospital and GP prescribing.</td>
<td>Agreed. The Department and NHS Scotland remain mindful of the issues raised in the Committee’s 3rd report 2004. Attention remains focussed on initiatives that improve prescribing effectiveness and deliver the potential savings identified by Audit Scotland. A system providing electronic access to prescribing information is currently being implemented in GP practices across Scotland. The system allows individual practices to identify appropriate targets under the Medicines Management area of the Quality and Outcomes Framework of the new GMS contract, and enables the subsequent tracking of progress against those targets. Good progress has been made in the managed introduction of new medicines into the NHS through the establishment of the Scottish Medicines Consortium (SMC). To date the SMC has issued advice to NHSScotland on approximately 200 new drugs and approved 148 for use in the NHS. Electronic prescribing has been established in Ayrshire Hospital as a precursor to developing standards for electronic prescribing systems throughout NHSScotland hospitals. A group has been established to take forward this work. One of the requirements will be the need for connectivity between the hospital and primary care sectors.</td>
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<td>FINANCIAL MANAGEMENT</td>
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<td>6</td>
<td>23</td>
<td>The Committee wishes to emphasise that Boards must address the financial position in a holistic way, actively managing the whole budget and using it to best effect - rather than identifying potential deficits and devising ways to &quot;plug&quot; any funding gaps.</td>
<td>Agreed.</td>
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| 7  | 27 | NHS Boards' savings plans must be:  
• realistic;  
• based, whenever possible, on achieving recurrent savings; and  
• seen as part of a wider sound financial management process. | Agreed. |
| 8  | 31 | There is evidence of a continuing over-reliance on non-recurring funding within some NHS Boards. In simple terms, some NHS Boards continue to live beyond their means year after year, using non-recurring funding to "balance the books" rather than bringing spending into line with their base budgets. This should not be allowed to continue. | We agree that the use of non recurring resources to meet recurring expenditure is inappropriate as a long term financial strategy and we expect NHS Boards to ensure that their underlying position is robust. We realise, however, that some non- recurring resource and non- recurring expenditure will always be necessary and NHS Boards should manage this within their total resources. Non recurring income and expenditure are unlikely to be eliminated completely and should be appropriately managed within the NHS Boards' overall financial resources. |
| 9  | 32 | Boards must ensure that they are not relying excessively on non-recurring funding to balance the books and the Department must monitor Boards' performance in this area more rigorously to ensure that Boards are not at risk. | Agreed. Monthly monitoring returns have been amended to include a more detailed analysis of the split between recurring and non-recurring resources and expenditure. This will be monitored on a monthly basis and followed up through the detailed financial monitoring process. This kind of analysis has been included within the financial planning information in the last couple of years. |
| 10 | 33 | The Committee notes that the current format of NHS accounts does not disclose the use of non-recurring funding. The Committee considers that this is not sufficiently transparent. The Committee recommends that in future NHS | We agree in part. The format of annual accounts is dictated by a number of factors including the requirements of resource accounting and the necessity to consolidate the information into the Scottish Executive overall accounts. We note the comments with respect to transparency. As stated above both the monthly monitoring returns and the financial plans now give more detail in relation to the split of recurring/non recurring income and expenditure and we believe that this addresses the point. |
| ANNEX |
|---|---|
| **Boards' accounts should disclose information on the use of non-recurring funding.** | We will ask NHS Boards to ensure this information is publicly available locally. We do not think it would be appropriate to include this analysis within the annual accounts. It is also not consistent with the way that information is analysed in other public or private sector accounts. |

### Quality of Financial Information and Costs

| 11 | 36 | The Committee again recommends that the Department ensure that accurate cost information for NHS Scotland is provided and that the quality of financial information is improved. |
| 12 | 37 | The Committee further recommends that in responding to this report the Department set out how the quality of financial information is to be improved. |

We agree that the quality of financial data needs to be improved. A number of groups exist in which the Department works with the Service to review and consider the range of financial information available. The groups work to ensure that the quality and consistency and financial information supplied across the service is improved. The introduction of a tariff system will allow costs and efficiency of different hospitals to be compared.

As stated above a number of groups now exist which are working to improve the quality and consistency of financial information. In particular in relation to pay modernisation a GMS Finance group and an Agenda for Change finance subgroup are both working to ensure consistent and robust financial information in relation to these pay contracts. In relation to more general financial information a financial data review group has been formed to consider a range of financial and activity information and how this should and could be improved in the future.

### PAY MODERNISATION

#### Estimating Costs

<table>
<thead>
<tr>
<th>13</th>
<th>39</th>
<th>The Committee considers that the Department failed to model pay modernisation costs adequately.</th>
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<td>Disagree. Considerable efforts were put into modelling pay modernisation. Cost estimates were adjusted on a regular basis reflecting the thoroughness and the degree of monitoring and continual tracking of costs which we have undertaken with NHS Boards. This is a sign of robust and thorough cost monitoring. Modelling costs for the delivery of new pay systems across 150,000 staff can never precisely forecast the exact costs – regular adjustments are inevitable, particularly where it is developed from close working with 23 different NHS Boards.</td>
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<td>The alternative to the iterative process described and the provision of regular updates on cost</td>
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<td>The fact that original cost estimates for pay modernisation were too low makes it more difficult for NHS Boards to keep within budget. Also, the cost of funding pay modernisation makes it more difficult for Boards to fund other new services.</td>
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<td>15</td>
<td>41</td>
<td>The Committee recommends that:</td>
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The fact that original cost estimates for pay modernisation were too low makes it more difficult for NHS Boards to keep within budget. Also, the cost of funding pay modernisation makes it more difficult for Boards to fund other new services.

Noted. National cost estimates for new pay systems are built on estimates of local cost impacts forecast by NHS Boards themselves. In managing their finances NHS Boards will update their estimates regularly, not only with regard to paybill costs, but in relation to all the other costs of running a local NHS system. To ensure that this can be managed effectively NHS Boards plan projected costs from pay modernisation into their budgets from an early stage, placing whatever provisions around the actual outturn that they judge are necessary.

For all strands of pay modernisation NHS Boards have had the necessary information on predicted costs ahead of implementation, allowing them to financially plan the local cost impact before the start of the financial year in which the pay systems have changed. Clearly it is not possible to precisely predict what the cost of such major change will be, given that this is dependent on individual negotiations and evaluations carried out with 150,000 staff, and there will therefore always be changes in local (and therefore national) estimates.

Pay modernisation is about rewarding staff fairly and building a reward structure for the future to enable service improvement and redesign. We believe better treatment of staff will lead to improved services for patients. One of our priorities is to invest in the NHS workforce and reward them fairly for what they do, in line with equal pay legislation, helping us to better recruit and retain staff in NHSScotland and to create the working patterns for a modernised NHS. We firmly believe that a better motivated, well-treated workforce will enable NHSScotland to deliver improved services to patients and ensure that new services can be delivered. In this way funding pay modernisation will open the way to providing the working conditions that allow new services to be developed.

The Committee recommends that:

Agreed. We have and will continue to produce estimates of the cost of pay modernisation based on the best available data at any point in time. Cost estimates produced prior to
• future cost estimates for the introduction of major initiatives be much more robust; and
• Boards and the Department jointly agree the estimating model for such new initiatives.

Implementation can only be estimates as out-turn costs are dependent on the way in which each contract is implemented by Boards. We rely on Boards to keep us informed on such changes.

Individual estimating models have been used for each of the different pay contracts. The original consultant contract cost model, which was the first model to be deployed, was the most top-down of the models, which we acknowledge gave it limitations. Even so, it should be noted that the contractual framework for consultants in fully priced form was published and notified to all NHS Boards over a year and a half ahead of the April 2004 commencement date, providing a period for NHS Boards to factor local costs into their financial planning.

Since then we have worked extremely closely with NHS Boards on further iterations of the consultant model and on cost estimates for the new GMS Contract and on Agenda for Change (AfC). The AfC model is based on close joint working between SEHD and payroll experts in NHSScotland, providing a financial modelling tool which NHS Boards have used to estimate local costs. The model is based on the Glasgow payroll, adjusted to an all-Scotland cost, and is regularly updated to reflect NHS Boards’ estimates.

All of these models are sophisticated tools which are as robust as the available data allows.

The Committee is very concerned that the benefits to patients of pay modernisation remain unclear. It is also still not clear how the impact of pay modernisation will be evaluated.

Realising Benefits

16 44

Noted. We would draw the Committee’s attention to the Health Department Letter (at Appendix A) outlining arrangements to performance manage and evaluate the benefits from all the strands of pay modernisation. This asks NHS Boards to produce Pay Modernisation Benefits Delivery Plans and regular progress reports. These plans and updates will detail the direct impact of pay modernisation in helping to deliver service improvements to patients.

The annual reviews of all NHS Boards this year - chaired personally by the Minister for Health other than the the State Hospital review - identify pay modernisation benefits as a priority item for discussion. As an example of the data underpinning the discussion of pay modernisation, the benefits flowing from the nGMS Contract are measured by ten strategic tests, supported by individual performance indicators, and Boards’ performance against these measures are evaluated objectively and rigorously.

The results of the Quality and Outcomes Framework for GP practices across Scotland were released in May (well ahead of other UK countries). These detail progress by Scottish
practices against the Framework’s quality indicators. The results show the significant gains for patients in quality treatment made by GP practices over the last year, as a result of the nGMS Contract.

### Meeting Scotland’s Needs

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<th>47</th>
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| The Committee is concerned that the new contracts being implemented under pay modernisation do not properly reflect Scotland's needs and circumstances. | Noted. Scottish Ministers are committed to a UK framework for NHS pay, as are Ministers in England, Wales and Northern Ireland. This means adoption of pay arrangements negotiated at UK level which reflect common needs and circumstances found in all four countries. ‘Scottish’ concerns, such as population distribution, health inequalities, remoteness, and urban poverty, also exist in parts of the other three UK countries, and are addressed in all three contracts.

These pay arrangements also respond to imperatives which are common to all UK countries. For example, the maximum 48-hour week is the requirement to comply with safe hours limits applied by the working time regulations, which are UK-wide. Similarly, the requirements for equity flowing from the Equal Pay Act, which are the basis for the job evaluation system under *Agenda for Change*, are UK-wide.

At the same time, these contracts have deliberately been designed to be flexible to local circumstances. For example:

- the new GMS Contract introduces a range of different contractual options (salaried GPs, Section 17c practices, GMS practices, enhanced services) and delegated arrangements which allow NHS Boards to contract for primary medical services in a variety of ways suited to local circumstances which was not available previously;

- The new consultant contract allows managers and consultants to design individual jobs which are responsive to local services, wherever they may be;

- the job evaluation system under *Agenda for Change* will allow for new jobs to be designed to meet local needs, but within an equitable grading structure.

Beyond these inbuilt flexibilities, significant Scottish-specific variations have been built into all these contracts. To give three examples for illustrative purposes:

- in the nGMS Contract a separate Scottish allocation formula for allocating resources...
to Scottish practices was negotiated. A particular feature of this is a weighting to better respond to the needs of Scotland’s rural and remote practices;
- the Scottish consultant contract includes a clause providing employers with the discretion to organise consultant activity on Saturday mornings as a way of maximising the potential capacity from consultants;
- with regard to Agenda for Change, Scotland has negotiated the right to agree Scottish-specific matters outwith the UK Agreement, such as the issue of a distant islands’ allowance to staff working in remote islands.

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<tr>
<th>Consultant Contract</th>
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<td>The estimating process for the consultant contract was not sufficiently comprehensive or accurate.</td>
<td>Noted. Estimates of the cost of pay modernisation, including the consultant contract, have been based on the best available data at any given point in time. Cost estimates produced prior to implementation can only be estimates as out-turn costs are dependent on the way in which each contract is implemented. It is also not possible to accurately predict the cost of a contract which is subject to over 3,000 individual job plan negotiations. Even so, it should be noted that the contractual framework for consultants in fully priced form was published and notified to all NHS Boards over a year and a half ahead of the April 2004 commencement date, providing the information for NHS Boards to estimate their costs and factor these into their financial planning.</td>
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<td>The Department was not able to separate out increases in consultant costs arising from higher numbers of staff, from increases resulting from pay modernisation. This demonstrates the poor quality of the information available. This is basic management information which should be readily to hand.</td>
<td>We agree with the Committee that such basic management information should be readily to hand. We are working with NHS Boards to ensure that the quality and timeliness of such data is improved. We are developing new performance management arrangements with Boards which will help this process and a new HR information system for NHSScotland being introduced this year will help underpin this. The need for better management information is also one of the reasons why we introduced the new consultant contract. For the first time it provides comprehensive management information on activities consultants are engaged in throughout their working week, and how these support the delivery of service objectives.</td>
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### Benefits

**20** 52  | The Committee entirely agrees that all NHS staff should be fully recognised for the work that they undertake - but the service also needs to ensure that recent investment will result in improvements to both patient outcomes and activity levels.  
  
The Committee considers that the Department does not have a clear strategy to ensure that these issues are reconciled.

**54** 46  | Noted. We have a very clear strategy and we are already beginning to see results. Our strategy is to invest in staff and reward them fairly for what they do, in line with equal pay legislation, helping us to better recruit and retain staff in NHSScotland and to provide the tools and levers with which to improve services to patients and achieve beneficial service redesign. The major strides taken by GP practices over the last year in achieving excellent standards of quality care against the nGMS Contract’s Quality and Outcomes Framework, is just the beginning of that process. There are also examples in anaesthesics, orthopaedics, ophthalmology and other areas of where the consultant contract is directly improving services.  
  
We have always been clear that pay modernisation is an ‘investment for reform’ package; that we have to invest money to reward staff fairly and provide the platform for working patterns that allow them to treat more patients quicker and better in a modernised patient-centred NHS. The extra costs of pay modernisation in 2004/5, over and above the planned costs projected through cost modelling, total £59m. This represents 1.3% of the overall paybill (including GMS allocations) of £4.5 billion. In our view this is a reasonable degree of tolerance in estimating the costs of introducing new pay systems for a workforce of 150,000.  
  
The ways in which we are managing the delivery of benefits from the contracts are explained in the response to paragraph 44.

**21** 54  | The Committee did not receive any evidence which convinced it that the consultant contract represents good value for money for the service in Scotland  

**54** 21  | Noted. Evidence of benefits comes after the initial cost has been incurred, and we are now at the stage when the initial investment has been made while the benefits are only just beginning to flow through. But we firmly believe in the long term this contract will turn out to be of significant value for money for the NHS. We consider it a great benefit to have established a contract which for the first time:  
  - provides a properly managed system of job planning whereby managers and consultants agree how each individual consultant organises all of his or her activity each week;  
  - in a way which directly supports the organisation’s objectives (and on which pay progression is dependent);
which allows managers to review at any time the nature of the consultant’s activities, or the way in which they are scheduled or organised, in order to bring about improved services to patients;

and which abolishes the previous practice of ‘double paying’ consultants extra fees for work done in NHS time.

All of these elements signify an important shift in the way in which employers contract for the services of consultants which is of major significance.

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<tr>
<th>GMS Contract</th>
<th>Costs</th>
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<td><strong>22</strong> 57</td>
<td>The estimated costs of the GMS contract for 2004/05 have increased from a figure of £64m in August 2004 to £85m (Col 974) as set out in evidence to the Committee in February 2005. The Department must ensure that these significant costs are translated into improved services and that the impact of changes are measured.</td>
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<td><strong>23</strong> 60</td>
<td>In written evidence to the Committee the Department stated that, while initially the high level of GP input to out-of-hours services would see costs increase, there was an &quot;expectation&quot; in many Board areas that out-of-hours services will develop a more multi-disciplinary team based approach over time. However, the Department has provided no evidence of how it will ensure that this change in practice takes</td>
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### Agenda for Change

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<td>The Committee is concerned that the full costs for implementation in 05/06 are up to £40m higher than the estimates for 04/05 originally given to the Committee.</td>
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<td>Noted. The reason for the cost increase of £40 million between 2004/5 and 2005/6 is that the 2004/5 costs are only over six months, given that <em>Agenda for Change</em> was effective from 1 October 2004, whereas the 2005/6 costs are full-year costs. This, plus the impact of pay inflation (at 3.225%), explains the rise of £40m in costs.</td>
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| 25 | 64 | It is not clear whether negotiations to agree the key elements of *Agenda for Change* and subsequent funding allocations acknowledged the disproportionate impact on Scotland given its higher staffing levels. The Committee requests further information from the Department on this point. |
|   |   | Noted. The cost modelling conducted by the Department and applied to funding allocations throughout all stages of the *Agenda for Change* negotiations took full account of Scottish circumstances and, in particular, staffing levels in NHSScotland. The modelling was based both on all-Scotland data on staffing profiles and working patterns held by the Department and on joint work with NHSScotland payroll experts using the Glasgow payroll database as a sample. |

### Additional Funding

| 26 | 67 | The fact that extra one-off payments have been necessary to fund pay modernisation may   |
|    |    | Noted. As the Committee recognises, financial management involves scrutinising budgets to identify underspending and prioritisation to ensure that resources are being applied to meet the Executive’s priorities. Judgement is then exercised in deciding whether to reallocate freed   |
therefore have meant cancellation, delay or reduced funding for other important initiatives. Up resources to address priorities. Following such an exercise it was decided to reallocate resources in March 2004 and June 2004 to help NHS Boards meet extra financial burdens flowing from the reform of pay and conditions for NHS staff, as well as to help further modernisation of the NHS in delivering patient care.

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<td>This is to be regretted not only because the direct patient benefits of these initiatives may have been reduced, but because many of these improvements would have enabled Boards to work more efficiently as well as more effectively.</td>
<td>Noted. Investment in pay modernisation is also investment in the levers to help bring about the service improvements which will enable the NHS to work more efficiently and effectively. Improvements can only be delivered through staff and will usually rely on staff developing new ways of working and acquiring new skills. These new contracts provide the conditions to do that. It should not be forgotten that the NHS itself made it very clear that these pay reforms were necessary in order to bring about the necessary modernisation of services.</td>
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**Modernising Medical Careers**

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<td>It is important that in planning for the introduction of this reform that the Department learn the lessons of pay modernisation.</td>
<td>Agreed. Work on both the introduction of the changes in education and on the service impact have been in progress for some time, led by an NHS Chief Executive and involving a wide range of interests.</td>
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<td>Planning for the introduction of this initiative must begin in earnest now. In responding to this report the Department should provide further information on this issue including any cost estimates which have been produced.</td>
<td>Agreed. A number of workshops have been held and all Health Boards submitted initial plans for the introduction of MMC to the Department in April but further work is required before reliable cost estimates can be produced.</td>
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**PRODUCTIVITY**

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<td>The decline in activity is particularly concerning given the high levels of investment in recent</td>
<td>Agreed. The Department shares the Committee’s concern about the apparent decline in activity set against the high levels of investment, and increased staff resources, while pointing out that recorded activity may lag behind actual activity and that some activity (for</td>
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<td><strong>DRIVING CHANGE</strong></td>
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<td><strong>Drivers for Change</strong></td>
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Agree. This is a challenge for healthcare systems internationally. The Centre for Change and Innovation has the task of getting to grips with this in Scotland.

CCI is currently running 5 national change programmes with significant reach across NHS Scotland. Patient Focussed Booking, for example, has been rapidly applied to all major Scottish acute hospitals; the Scottish Primary Care Collaborative will be engaging with 40% of GP practices in Scotland (an unprecedented level of engagement) by end 2005 and the new Unscheduled Care Collaborative is working in every NHS Board area.

The Outpatients Programme has engaged 11 NHS Boards in the redesign of orthopaedic outpatient services; 11 NHS Boards in Dermatology Redesign; 10 NHS Boards in ENT redesign and all four regional centres in plastic surgery. The Doing Well Programme is working with 10 NHS Boards on developing access to services for people with mild to moderate depression and engages with all NHS Boards through a development network. All programmes are required to develop a “spread and sustainability” strategy for their activities.

It will be important for the Centre in the months ahead to plan future activities with strong alignment to the national priorities set out in Fair to All, Personal to Each (December 2004) and the implementation of the Executive’s response to the National Framework for Service Change and to have stronger alignment of improvement activities with performance management.

One such development is the development of the TOP 20 Actions for Change for cancer services developed by the Cancer Services Improvement Programme during 2005 which is giving a real focus to the improvements that Regional Networks need to drive through this year.

Noted. The Department announced on 29 July a new focus on delivery supported by proposals for improved NHS planning, enhanced performance management arrangements, and a new approach to performance support and improvement. The changes are designed to help ensure delivery of the Executive’s objectives for the Health portfolio and will be implemented between now and the beginning of 2006. They will help ensure a closer focus on the achievement by NHS Boards of quantified plans directly linked to national priorities.
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<th>37</th>
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<th>The Committee has noted the rate of improvement in the performance of some areas of the NHS in England. The Committee is not making a case for the same measures currently operating in England to be introduced in Scotland. However, Scotland needs its own distinctive and coherent strategy for improving performance within the NHS - the Committee considers that at the moment this is lacking.</th>
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<td>The Department must set out a clear strategy for how the large scale reform envisaged in the service will be driven forward.</td>
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| | | Disagree. The Department has supported Ministers in developing distinctive health policies that meet Scottish needs. For example, there has been a strong focus on health improvement and reducing health inequalities in response to Scotland’s poor health record, and a coherent focus on preventing and treating heart disease and cancer which has contributed to sharp reductions in premature mortality rates from these diseases. Longest waits for heart treatment have also reduced sharply. Longest waits for inpatient and daycase treatment have been reduced and further reductions are being delivered. However our approach to improving performance in the NHS can be further improved, and that is why we announced the new focus on delivery on 29 July, as outlined in response to Recommendation 36 above. |
| | | Agreed. We believe that performance improvement across the NHS for the benefit of all patients will be driven forward through a number of linked actions. These include:

- investment in new and improved NHS services, and greater use of independent sector resources for diagnostic and planned surgical procedures;
- clear and ambitious targets;
- active planning and performance management;
- effective intervention to support and turn round weak performance;
- redesign and modernisation of services including more flexible use of staff;
- strategic investment in better information management and technology;
- more separation between emergency and planned care;
- and working with GPs and other primary care practitioners to ensure that as much care as possible is given to people in or near their homes, thus avoiding the need for admission to hospital. |

However steps to increase performance must always be taken in a context of maintaining health care quality and placing the patient at the centre of care. Consequently the work of NHS Quality Improvement Scotland in setting standards and reporting on Boards’ performance against these will continue to be very important. |

These measures add up to an effective change programme. The Department will continue to monitor closely the impact on NHS performance of this performance to ensure that the Executive’s objectives for the Health portfolio are met.
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<th>INFORMATION</th>
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<td><strong>Review of Data and Statistics</strong></td>
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<td><strong>E-Health</strong></td>
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<td>Department has taken is failing to deliver the scale of change needed quickly enough.</td>
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**SCOTTISH EXECUTIVE HEALTH DEPARTMENT**  
July 2005
Dear Ms McKinlay

AUDIT COMMITTEE, 5th REPORT, 2005 (SESSION 2)
SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE
OVERVIEW OF THE FINANCIAL PERFORMANCE OF THE NHS IN SCOTLAND 2003-04

Please find attached the Health Department’s formal response to the Audit Committee’s report on the Overview of the Financial Performance of the NHS in Scotland 2003-04 which was published on 1 June 2005.

Yours sincerely.

KEVIN WOODS